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STATE OF DELAWARE
DEPARTMENT OF STATE

DIVISION OF PROFESSIONAL REGULATION

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Delaware Examining Board of Physical Therapists and Athletic Trainers

APPLICANT SPECIAL ACCOMMODATIONS REQUEST FORM

Section I – Applicant Information

Name: _____
Last First Middle

Current Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Alternate Phone Number: _____

Email Address: _____

Date of Birth: ____/____/____ Gender (circle one): Male Female
Month Day Year

Section II – Information About Your Disability and Requested Accommodations

What type of disability do you have? *Please indicate the specific diagnosis.*

When was your disability first diagnosed? _____

How does your disability affect your daily life?

How does your disability affect your ability to take computerized examinations?

What accommodations are you requesting during the examination?

<input type="checkbox"/> Additional Time – Time and a half	<input type="checkbox"/> Reader
<input type="checkbox"/> Additional Time – Double Time	<input type="checkbox"/> Scribe
<input type="checkbox"/> Paper and Pencil Exam	<input type="checkbox"/> Separate Room
<input type="checkbox"/> LARGE PRINT Paper and Pencil Exam	<input type="checkbox"/> Other _____

What accommodations have you received in the past for the following exams?

National Physical Therapy Exam _____

PT/PTA School Exams _____

Undergraduate College Exams _____

Standardized Exams (e.g., SAT, GRE, etc.) _____

Section III – Documentation Requirements

A comprehensive and current report (no more than three years old) from a qualified examiner appropriate for evaluating your disability must accompany this request form. The report must include the following:

- Name, title, credentials and area of specialization for the qualified examiner
- Specific diagnosis
- Specific findings in support of the diagnosis (include relevant test results)
- Recommendation for specific accommodations
- Rationale for requesting specific accommodations

Section IV – Candidate Affirmation

My signature on this form affirms that the information I have provided on this request is true and accurate. I have truthfully represented my disability and the impact it has on my daily life and computerized examinations.

Applicant Signature

Date